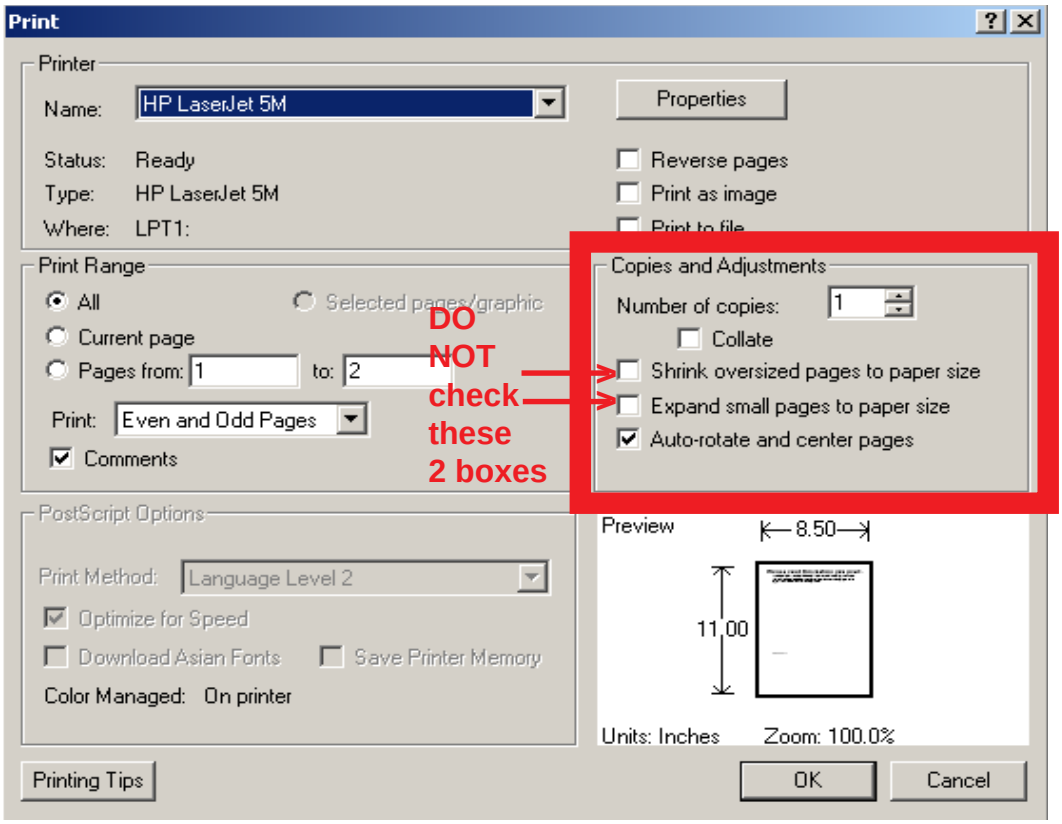
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (8/2003)

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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

X-Ray Technician Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

X-Ray Technician

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 686-030 (REV 8/2003)

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Washington State Department of Health

General Information For X-Ray Technicians

"Registered x-ray technician" means a person who is registered with the department, and who applies ionizing radiation at the direction of a licensed practitioner.

A registration may be issued to those individuals who have had no formal education or have not completed an accredited radiography, therapeutic, or nuclear medicine program(s).

Please review and follow the instructions carefully so that the application may be processed promptly. If you have questions concerning the application process, please call (360) 236-4943.

Mail the application and fee to: Department of Health
X-Ray Technician Program
P.O. Box 1099
Olympia, WA 98507-1099

Supporting documentation or correspondence mailed after submission of the application should be addressed to:

Department of Health
X-Ray Technician Program
P.O. Box 47869
Olympia, WA 98504-7869

Registered X-Ray Technician Fees

All application fees are non-refundable. Please make check or money order payable to the Department of Health.

Registration/New Application	$35.00
Renewal Fee	35.00
Late Renewal Penalty Fee	35.00
Expired Credential Re-issuance	35.00
Replacement of Registration	15.00
Verification of Registration	15.00

Application Instructions

Please print throughout the entire application form except for the signature line. If sections of the application are not applicable, use the initials N/A.

1. **Demographic Information:** Complete all information including birth date and social security number.

   Facility/Agency Name: Complete all information regarding your employer and phone number.

2. **Previous Licensure:** Complete all information, if applicable. If any of the following credentials were issued to the applicant from **another state**, please send the enclosed state verification form to the state or states where applicant was credentialed: license, certification, registration, temporary or reciprocity. Out of state verification of credentialing must be received by DOH before a credential is issued.

3. **Personal Data:** The applicant must answer the personal data questions and provide a letter of explanation and any supporting documents relative to any "yes" response(s). Radiologic Technologists and X-Ray Technicians are subject to the Uniform Disciplinary Act (RCW 18.130) which requires answer to these questions.

4. **Aids Education and Training Attestation:** The applicant may sign and attest to having completed a minimum of seven (7) hours of Aids education and training or provide certificate of completion. Please keep your records for two (2) years documenting attendance and description of the learning.

5. **Professional Training and Experience:** Complete all information, if applicable.

6. **Applicant Attestation:** The applicant must sign the Applicant Affirmation statement which allows the Department of Health access to information regarding the applicant and to certify that the applicant has read and understands the law.

Documentation Checklist for Registration as a Registered X-Ray Technician:

There are no educational requirements for registration. The individual works under the direction of a licensed practitioner.

☐ Complete application.

☐ Registration fee of $35.00.

☐ If applicant is/was licensed, certified, or registered in another state or other states, complete Part 1 of the Out of State Verification of Licensure/ Certification/Registration form and forward to the appropriate out-of-state Commission/Board/Committee(s) for completion and return to the department.

☐ Verification of seven (7) hours AIDS education and training by signing Aids Education and Training Attestation section on the application form. See WAC 246-12-280 for details of acceptable documentation.

Renewals

The expiration date of your certification or registration will be on your next birthday.

All subsequent renewals will be due every other year on your birthday. A courtesy reminder will be mailed to you approximately 45 to 60 days prior to the expiration date of your registration. For this reason, it is important to keep this office advised in writing, of any address and/or name changes to ensure receipt of this notice. It is the responsibility of the certified or registered practitioner to maintain current status with the Department of Health.

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only	
REGISTRATION #:	DATE ISSUED:

Registration #

Application For Registration As An X-Ray Technician

Applying for Registration as: ☐ X-Ray Technician

Please Type or Print Clearly— Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

city	state	zip	county

FACILITY/AGENCY NAME	TELEPHONE NUMBER ( )

STREET ADDRESS

CITY	STATE	ZIP	COUNTY

INDICATE CURRENT PRACTICE SETTING (EXAMPLE: HOSPITAL, CLINIC, ETC.)

PLEASE NOTE: Individuals who work under the supervision of a dentist or a chiropractor, and/or who are authorized to apply ionizing radiation to human beings as a part of their practice are not required to register under Chapter 18.84 RCW.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS HOURS**.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

Gender ☐ Female ☐ Male	Birthdate	PLACE OF BIRTH	maiden/FORMER name(S)

2. Previous Licensure

List all states where credentials are or were held. (Previous credential to include license, certification or registration.) Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YR ISSUED	NUMBER		EXAM	OTHER	
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. AIDS Education and Training Attestation

☐ School Curriculum
☐ Employer/Other

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

5. Professional Training And Experience

List in chronological order all professional education and experience including college or university (pre-radiography, therapeutic and/or nuclear medicine program), technical or professional and practice pertaining to the profession for which you are making application. If applicable, include all periods of time from the date of graduation from a radiography, therapeutic, and/or nuclear medicine program to present whether or not engaged in activities related to your practice as an x-ray technician.

NAME AND LOCATION OF INSTITUTION, PLACE OF PRACTICE OR OTHER	DATES		DEGREE/CERTIFICATE AND DATE RECEIVED, NATURE OF EXPERIENCE OR SPECIALITY
	FROM (MO/YR)	TO (MO/YR)	

6. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state and federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____

Signature of Applicant Date

Official Use Only

Washington State Records Center

Washington State Department of Health
Radiologic Technology Program
P.O. Box 47869
Olympia, WA 98504-7869

Verification Of Out-Of-State Licensure / Certification / Registration
X-Ray Technician

PART 1: Note to Applicant

Complete Part 1. Submit form(s) to all ***state*** x-ray technician commissions/boards/committees where you have ever been licensed, certified, or registered.

Name _____

I was licensed/certified/registered by the _____ Commission/Board/Committee of
STATE

X-Ray Technicians under the name _____

My original license/certification/registration number is _____

My Address is _____

_____
SIGNATURE OF APPLICANT

PART 2

To be completed by the ***state*** x-ray technician commission/board/committee and returned to the Washington State Department of Health at the address provided above.

License/Certification/Registration issued on _____ Number _____

Applicant licensed by: Exam _____ Endorsement _____ Waiver _____

Status of License/Certification/Registration: ☐ Current ☐ Not Current If not, explain _____

_____

Has license/certification/registration ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, placed on probationary status or under investigation.) ☐ Yes ☐ No If yes, explain _____

_____

_____
SIGNATURE

(SEAL)

_____
NAME/TITLE

_____
STATE

This form may be duplicated as needed.